

***PLEASE FILL OUT COMPLETELY AND SIGN AT THE 'X'**

TODAY'S DATE: _____

Patient Name: _____ **Birthdate:** _____ **Age:** _____

Address: _____ **Sex:** _____ **Marital Status:** _____

City: _____ **Zip Code:** _____ **Home Phone:** _____

Social Security Number: _____ **Work Phone:** _____

Employer/School Name: _____ **Referring Doctor:** _____

Employer address: _____ **Patient E-mail :** _____

Spouse's Name: _____ **Spouse's SS Num:** _____

Spouse's Employer Name: _____ **Spouse's Work Phone:** _____

Spouse's Employer Address: _____ **Contact Person:** _____

Person Responsible for Bill: _____ **His Home Phone:** _____

Address of the Person: _____ **His Work Phone:** _____

INSURANCE COVERAGE #1

Insurance Company Name: _____ **Phone Number:** _____

Address: _____ **Group #:** _____

ID#: _____ **Plan #:** _____ **Medical Grp Name:** _____

Cardholder's Name: _____ **DOB:** _____ **Relationship to Patient:** _____

Effective Date: _____ **Filing Order:** _____ **Authorization #:** _____

INSURANCE COVERAGE #2

Insurance Company Name: _____ **Phone Number:** _____

Address: _____ **Group #:** _____

ID#: _____ **Plan #:** _____ **Medical Grp Name:** _____

Cardholder's Name: _____ **DOB:** _____ **Relationship to Patient:** _____

Effective Date: _____ **Filing Order:** _____ **Authorization #:** _____

WORKMEN'S COMP INS NAME: _____ **Phone Number:** _____

Address: _____ **Date of Injury:** _____

Agent's Name: _____ **Claim Number:** _____

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGN BENEFITS:

I, the undersigned, has insurance coverage as stated above and authorize you to release any medical information necessary to process the claims. I further assign directly to Rao V.Sunkavally,M.D.,F.A.C.S., all surgical and/or medical benefits, if any otherwise payable to me for the services rendered. I further agree to pay all charges not covered or not paid by my Insurance Company. I understand that insurance problems are not considered an acceptable reason for lack of payment of my account.

X _____
Signature of Patient or Responsible Person

X _____
Date Signed

X _____
Print name of person signing

Please continue on the back page

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How did you know about our doctor? Referring MD Friend/relative Internet Site Phone book Clinic/ER Other

Were X-rays taken for your present problem? _____. If yes, When? _____ Where? _____

What kind of X-rays did you have? _____ Do you have a copy/report? _____

CONSENT TO TREATMENT:

I consent to the treatment by Dr. Rao V.Sunkavally, M.D.,F.A.C.S. I agree that I will be responsible for keeping my appointments for follow-up visits, for undergoing diagnostic procedures and for following the treatment instructions that will be given by Dr.Rao V.Sunkavally, M.D.,F.A.C.S. I will also be responsible for seeing other specialists as and when recommended by Dr.Rao V.Sunkavally, M.D.,F.A.C.S.

I understand that in the event of me not following the above outlined responsibilities, Dr.Rao V.Sunkavally, M.D.,F.A.C.S will not be held responsible for any adverse outcome of my condition.

I have been informed by this office that the products used in the course of my treatment (such as resuscitation products, catheters and collection devices) contain a chemical known to the State of California to cause cancer. (Prop.65)

X _____
Signature of Patient or Responsible Person.

X _____
Date signed.

COMPLETION OF FORMS:

I understand that this office charges \$20.00 for filling out private disability forms or other forms, or for preparing letters for whatever purpose. I also understand that this charge is for each form or letter that this office is requested to fill out. I further understand that this office requires 7 days for completion of my request.

X _____
Signature of Patient or Responsible Person.

X _____
Date signed.

FINANCIAL OBLIGATIONS:

In return for the services to be rendered, I hereby agree and individually obligate myself to pay the account of this Office. However, if I am eligible to receive benefits under a healthcare service plan with which this Office has contracted, I shall not be obligated to pay for services covered under the plan which are paid pursuant to the contract. All amounts past due for more than sixty (60) days are subject to a one and one half (1½) percent interest charge. Should my account be placed for Collection, I agree to pay all Collection Costs including Attorney's fees and Court Costs.

I have received this Disclosure Statement prior to any service or Collection charges made to my account.

X _____
Signature of Patient or Responsible Person.

X _____
Date Signed.

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